

PRINTED: 07/21/2011  
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN8204	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  07/18/2011
NAME OF PROVIDER OR SUPPLIER  GREYSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

*[Signature]*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

*Administration*

(X6) DATE

8/3/11

6899

OEJS21

If continuation sheet 1 of 1